Heritage Lifecare Limited - Edith Cavell Lifecare

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Edith Cavell Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 February 2022 End date: 22 February 2022

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Heritage Healthcare Limited (HLL) own and operate Edith Cavell Lifecare, in Christchurch. The facility has capacity to take 59 residents, for rest home or hospital level care. Due to the registered nurse shortage the facility is only using 50 beds. All beds are dual purpose. The facility is managed by a care home manager and is presently being supported by a temporary HLL 'roaming' clinical services manager with support from a regional manager and staff from national office.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

There were no residents with Covid-19 in the facility, however, four staff members had been 'stood down' as they were close contacts of a person who had or was suspected of having Covid-19. The staff were being tested on the day of audit, with one staff member being negative. The care home manager described their plans to make some rooms isolation and how they would manage staffing of this area. There was evidence of sufficient personnel protective equipment being available and training occurring for staff.

A strength of this organisation is their teamwork and dedication to their residents. Areas for improvement were identified during the audit related to the reporting on the business plan which includes quality, analysis of quality data, resident meetings, annual performance reviews and completion of the risk register.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Few complaints are received by the provider. When there is a complaint they are managed by the care home manager who also maintains the register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Business and quality and risk management plans included the vision, direction and values of the organisation. Reporting of clinical indicators occurs automatically through to the regional manager (RM) and national office, as well as monthly reports on the services provided. The care home manager is new to aged care, and is suitably qualified to manage the facility.

The quality and risk management system are available and included collection and analysis of clinical indicators that identify trends. Corrective actions are undertaken when improvements where identified. Staff are involved and feedback.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified rated and mitigated. Policies and procedures support service delivery to all residents, were current and are under review.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review for most staff. Staffing levels and skill mix is challenging but meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Verbal handovers and communication sheets assist in guiding continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a good standard.

The planned activity programme is overseen by a diversional therapist and an activities co-ordinator and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current Building Warrant of Fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented Heritage Lifecare policies and procedures to minimise the use of restraint, with staff being aware of the process. During the audit there were no restraints and two enablers in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	34	0	5	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy meets the requirements of Right 10 of the Code. Residents and family are informed of the process as part of the admission pack. There is a suggestions box and complaints and feedback forms at the reception area. Residents and family members are aware of this and most stated if they had an issue they would speak to the RN or the manager. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. There were three complaints in 2021, all had been closed to the satisfaction of the complainant. Timeframes for response met the requirements of the Code and any action required related to the complaint had been undertaken. One complaint had been managed with the assistance of the Health and Disability National Advocacy Service. A complaints register is in place for 2022, no complaints had been received this year to date. The care home manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Staff knew how to access interpreter services, although reported this is a rare occurrence. The manager was able to give an example of how they had managed a resident who had English as a second language, with the support of the family, Google translate and picture boards.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Heritage Lifecare Limited (HLL) business plans 2020 and facility specific plan 2021 showed goals, with requirements and measures of success. These are reviewed annually. They outline the organisation's values and mission statement which were reviewed a few years ago. The facility business plan has quarterly reporting requirements which had not been undertaken, this is an area for improvement (See 1.2.3.7). The care home manager provides monthly reports to the national office showed adequate information to monitor performance is reported including financial, emerging risks and issues. The service is managed by a care home manager (CHM) who has previously worked as a senior manager in hospitality both here and overseas. They are new to aged care and has been in the position since October 2020. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirmed knowledge of the sector, regulatory reporting requirements and maintains currency through attending HLL and New Zealand Aged Care Association meetings and newsletters. The facility holds a residential aged care contract with the local DHB for long term hospital level care (15) and rest home level care (26), respite care and palliative care. They have eight occupational rights agreement care suites (three rest home and one hospital level) and have private paying residents (five) who are not assessed by the Needs Assessment Agency.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, an audit plan, clinical incidents/indicators including infections, pressure injury, wounds, restraint use and falls. There is a process for annual residents and family satisfaction survey, the 2021 survey was provided and shows overall satisfaction with the services being provided. There have been no resident meetings occurring, and this is an area for improvement. Managers meet daily and notes are kept of these meetings, monthly staff meetings are occurring and health and safety meetings. There was no meeting occurring which reviewed, analysed all the elements of quality management. Clinical indicator data was sighted by month and quarterly reporting for 2021, carried out by the clinical manager. This is an area for improvement. Staff were seen undertaking audit activity and corrective actions were sighted on these forms.

		Heritage Healthcare Limited (HLL) provide the organisation wide policies, procedures and guidelines and cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool. Policies are based on best practice and HLL have been working on updating these documents with the majority being current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. There is a HLL risk register, which includes health and safety risks and the facility wide risks. It includes the area of risk, the level or risk, mitigation strategies and review of risks. The home care manager was able to describe the processes for the identification, review of risks. However, was not aware of how to add risks to the register. This is an area for improvement. The care home manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There are health and safety representatives who undertake monitoring and attend the health and safety meetings.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events related to staff or property on an accident/incident form, available on the organisations intranet. These would go to the care home manager or clinical service manager as appropriate. Corrective actions are documented on the form and these are discussed at the health and safety meetings. Resident accidents/incidents are recorded on the electronic management system and these inform the clinical indicators process, which is available to senior management. An escalation process is in place based on a risk matrix, to ensure high risks are brought promptly to the attention of senior staff. Two incidents were documented, both were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. One incident involved an external contractor which resulted in the company reporting the incident to Worksafe. This provided good learning for the care home manager on processes which should have been put in place. The care home manager described essential notification reporting requirements, including to Worksafe for staff injuries, and for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are	PA Low	HLL have a range of policies and flow charts which cover human resources management. These showed how human resources at national office were supporting facility management. The processes are based on good employment practice and relevant legislation. The recruitment process includes an application form, short listing, visa and referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed (seven) confirmed the organisation's policies are being consistently

conducted in accordance with good employment practice and meet the requirements of legislation.		implemented and records are maintained. All health professionals (nurses, general practitioner, pharmacists and dietitian) have a current annual practising certificate. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation, however not all staff had undergone an annual performance review. This is an area for improvement. Continuing education is planned on an annual basis, including mandatory training and competency requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (there were three commencing training, one on level three and 16 on level four) education programme to meet the requirements of the provider's agreement with the DHB. The facility has an assessor for the programme and are also supported by an HLL assessor. All registered nurses are competent and have maintained their annual competency requirements to undertake interRAI assessments. RNs are encouraged to be part of the local DHB performance development and recognition programme and this was sighted in one RN's file and confirmed by them. Records reviewed demonstrated completion of the required training in 2021, due to the clinical manager resignation in January training has yet to occur for 2022.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The care home manager stated the staffing levels had been reviewed in January and due to the number of staff vacancies it had been agreed to hold resident numbers to 50 to ensure they could safely meet the resident's needs. The facility has had vacancies for three registered nurses (RN) and, a part time kitchen assistant. A RN has been made an offer of employment and is also awaiting immigration completion. An offer has been accepted for the clinical service managers position and has been accepted, they cannot commence for eight weeks. The roaming clinical service manager will move to another facility in two weeks. Observations and review of the two-week cyclic rosters confirmed that overall adequate staff cover had been provided. This included residents in the ORA suites. Staff are doing extra duties to cover shifts. The set roster has two RNs on morning and afternoon duties and one at night. There were a number of mornings and afternoon duties with only one RN and three night duties where a RN was unable to be found to cover the duties. These duties have been covered by senior care givers who are medication competent, and have a current first aid certificate. If this is at night an RN was on-call for support. The care home manager has informed the Ministry of these shortages via a section 31 notification. The shortfall is a continuing issue for ongoing rosters. This has been compounded by the resignation of the clinical services manager in January, a temporarily HLL roaming clinical manager is with the facility for two weeks and this will be reviewed ongoing.

		All RNs and some care givers have a current first aid certificate. Care staff reported their dedication to the residents. The stepping up of care givers to assist with the shortage of RNs was seen as meeting the needs of the organisation. However, care givers were getting tired and they knew management were doing their best to recruit staff. Residents and family interviewed did not raise concerns about staffing and were happy with the care staff and management.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The RN observed, demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Due to the RN shortage care givers who are medication competent are administering medications as well as RNs. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. The process for competency for residents who wish to self-medicate was explained but there were no residents doing so on the day of audit. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food,	FA	The food service is provided on site by a cook and kitchen team. They are currently advertising for a second cook. The menu is in line with recognised nutritional guidelines for older people. The menu follows summer and winter

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		patterns and has been reviewed by a qualified dietitian within the last two years (15 January 2021). Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Christchurch City Council and is current until 2 March 2022. Review had taken place and the facility is awaiting the new certificate. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Modified textured food is purchased from an approved provider. Special equipment, to meet residents' nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents' weights were stable with supplements provided for those requiring them. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The general practitioner (GP) interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the	FA	The activities programme is provided by a registered diversional therapist, and an activities coordinator. The programme is developed monthly and is provided over seven days. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on resident engagement at the time and feedback provided in discussion and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Van outings are provided for the residents for shopping and trips to local places of interest. Residents interviewed confirmed they find the programme varied and interesting.

service.		Residents were observed to be engaged in an entertainment session on the day of audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The 'Stop and Watch' tool is actively used and registered nurses document on it what action was taken. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for eye infections, wounds, and changes in medication. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness ((BWoF) expiry date 1 December 2022) was publicly displayed. Monitoring requirements to meet the requirement of the BWoF was being undertaken. There has been no alterations or structural changes since the last audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, care home manager, regional and national quality managers. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. There have been no outbreaks since the last audit.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. An RN is currently overseeing restraint coordination, until a clinical service manager is appointed. They demonstrated a sound understanding of the organisation's policies, procedures and practice. Restraint has not been used in the facility for over a year. Staff were seen to monitor residents closely, sensor mats are in use and lower beds where required. There is a folder which contains the policy a job description of the restraint coordinator role and six-monthly monitoring of the use of the enable or restraint. On the day of audit, no resident had restraints in use and two residents were using enablers, which were the least restrictive and used voluntarily at their request. The two residents spoken with were able to say that they wished to use of the bed rail for comfort and safety and staff were responsive when they wished them to be put down. A similar process is followed for the use of enablers as is used for restraints.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Low	Heritage Healthcare Limited (HLL) has an organisation quality and risk management system which includes health and safety risks. This includes an annual residents and family members survey. A copy of the 2021 survey was provided. There was no resident meetings occurring, the CHM is very visible to the residents and residents attend diversional therapy arranged activities. However other than the annual survey residents were not given the option of attending a formal regular meeting to be kept informed of what is occurring and give their feedback. This was confirmed by the care home manager, diversional therapists and residents.	There has been no resident meetings occurring on a regular basis to allow residents to have input into the service.	A resident meeting occur on a regular basis to allow for communication to occur. 90 days

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Clinical indicators including infections, pressure injury, wounds, restraint use and falls are reported through the patient management system and are available to facility clinical managers, regional and national managers. These are trended on a monthly basis and quarterly analysis and trending occurs. However, there is no meeting occurring which brings together all quality information such as complaints, incidents, risks, and clinical indicators to allow the facility to see carry out overall review, analysis and trending.	There is evidence of the clinical indicators being entered, data is analysed and available for managers. However ,at the facility level there is no meeting occurring where key components of service delivery are being brought together for discission analysis and trending.	A process be put in place to bring quality data together to allow for overall analysis, trending and evaluation. 180 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Heritage Healthcare Limited (HLL) has a business plan which is shared with facility managers. Each facility has their own business plan, the last one for Edith Cavell was 2021. This describes five goals, cover areas of finance, resident's satisfaction and staff satisfaction, quality, clinical and health and safety and property and maintenance. These are to be reported on quarterly however this has not been occurring.	The facility business plan, requires quarterly reporting on goals and there was no evidence of the goals being reported.	The business plan template be completed quarterly to ensure goals, including quality are being reported on. 180 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services.	PA Low	There is a HLL risk register, which includes health and safety risks and the facility wide risks. In reviewing the incidents if there was a high level of risk identified related to one incident and this was not sighted in the register. The care home manager was unsure how this would occur.	There is evidence that potential and actual risks have been identified and are documented in the HLL risk	Risks identified as high level be added to the risk register.

This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.			register, this includes health and safety risks. However, there is no evidence that a high-level risk identified had been added to the risk register.	180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is evidence on a spreadsheet and in a sample of files reviewed that clinical staff have undertaken a performance review. However, no administration staff (14) have not had a performance review and this was confirmed by the home care manager and a staff member.	Not all staff had undergone an annual performance review.	All staff should have an annual performance review as per organisational policy. 180 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.